FH

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

MPA/148459

PRELIMINARY RECITALS

Pursuant to a petition filed April 01, 2013, under Wis. Stat. §49.45(5), and Wis. Admin. Code §HA 3.03(1), to review a decision by the Division of Health Care Access and Accountability n/k/a the Office of the Inspector General (OIG) in regard to Medical Assistance (MA), a hearing was held on May 29, 2013, at Milwaukee, Wisconsin. The record was held open to allow the OIG time to respond to new evidence presented at hearing. The OIG provided its response on June 21, 2013. The petitioner replied to that response on July 9, 2013.

The issue for determination is whether the OIG correctly modified petitioner's prior authorization (PA) request for physical therapy (PT).

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

Attorney Patricia N. Engel
16655 W. Bluemound Road, Suite 270
Brookfield, WI 53005

Respondent:

Department of Health Services
1 West Wilson Street
Madison, Wisconsin 53703

By: written submittal of Pamela J. Hoffman, PT, DPT, MS
Division of Health Care Access and Accountability
1 West Wilson Street, Room 272
P.O. Box 309
Madison, WI 53707-0309

ADMINISTRATIVE LAW JUDGE:
Kelly Cochrane
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Waukesha County and is certified for MA.

2. Petitioner is 4 years old and lives at home with his family. He is diagnosed Werdnig Hoffman Disease-SMA Type 2, muscle weakness, hypotonia, poor postural control and delayed development.

3. On January 23, 2013 the petitioner's private PT provider submitted a PA request (PA# [redacted]) for petitioner to receive private PT twice weekly for 26 weeks. That PA was returned to the provider on February 1, 2013 requesting further information to support the medical necessity of the requested services. The provider responded on February 7, 2013. Exhibit 2.

4. The Plan of Care (POC) for the requested PA identifies the following PT goals for petitioner:

    1. Short sit with the abdominal binder at a table and participate in an upper extremity play activity with supervision for 5 minutes.

    2. Demonstrate expiration on the spirometer to 1400cc/sec.

    3. Utilize upper extremities into the supporting surface for recovery in short sitting.

    4. When [redacted] is fatigued in short sit he will ask for a break rather than let himself fall over. See Exhibit D.

5. On February 19, 2013 the OIG issued a notice to petitioner indicating that it was modifying the PA request to 13 sessions (or 2x per month) because it did not find the level of PT requested to be medically necessary. Exhibit 3.

DISCUSSION

Physical Therapy (PT) is covered by MA under DHS §107.16 of the Wisconsin Administrative Code. Generally it is covered without need for prior authorization (PA) for 35 treatment days per spell of illness. Wis. Admin. Code, DHS §107.16(2)(b). After that, PA for additional treatment is necessary. If PA is requested, it is the provider's responsibility to justify the need for the service. Wis. Admin. Code, DHS §107.02(3)(d)6.

In determining whether to grant prior authorization for services or equipment, the OIG must follow the general guidelines in DHS §107.02(3)(e). That subsection provides that the OIG, in reviewing prior authorization requests, must consider the following factors:

1. The medical necessity of the service;
2. The appropriateness of the service;
3. The cost of the service;
4. The frequency of furnishing the service;
5. The quality and timeliness of the service;
6. The extent to which less expensive alternative services are available;
7. The effective and appropriate use of available services;
8. The misutilization practices of providers and recipients;
9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including Medicare, or private insurance guidelines;
10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;

11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and
12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

The key factor of the 12 listed above is "medical necessity", which is defined in the administrative code as any MA service under chapter DHS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Wis. Adm. Code, DHS §101.03(96m).

"Medically necessary" is therefore more of a *legal* term as opposed to a *medical* term. Therefore, while a medical professional or provider may conclude an item is "medically necessary" it is the OIG which must adjudicate the request and determine whether the item or service for which payment is sought meets the legal definition of "medically necessary." In prior authorization cases the burden is on the person requesting the PA to demonstrate the medical need for the services. Wis. Adm. Code, DHS §§107.02(3)(d) and §106.02(9)(e)1.

In this case the OIG modified the PA request because it determined that the *level* of PT requested was not medically necessary. The evidence was voluminous and much time has been taken to review it. In sum, I break the agency's position into 3 main issues: insufficient evidence to show petitioner had made functional progress within the last 6 months, that the private PT did not provide certain measures of petitioner's impairments to show progress, and that the petitioner's home exercise program (HEP) and PT at school (1x/wk) provide interventions to prevent, identify and treat his disability, and maintain his skills through routine and repetitive participation; thus, private PT twice weekly is not supported.

As to the measure of progress, it appears that the agency is asking for the kinds of measurements one can get through manual muscle testing (MMT) and other like testing. The agency's basis for this is founded upon the rules about when a PA will be approved, which states in relevant part:

e) *Extension of therapy services.* Extension of therapy services shall not be approved beyond the 35-day per spell of illness prior authorization threshold in any of the following circumstances:
1. The recipient has shown no progress toward meeting or maintaining established and measurable treatment goals over a 6-month period, or the recipient has shown no ability within 6 months to carry over abilities gained from treatment in a facility to the recipient's home;…

Wis. Adm. Code §DHS 107.16(3)(e)1(emphasis added).

Petitioner provided a Consensus Statement for the Standard of Care in [SMA] (hereinafter "Statement"). See Exhibit H. The agency correctly points out that the Statement found that for the SMA "sitters" category, of which petitioner is included, that measurements of contractures and strength are part of evaluations in physical therapy. See Exhibit H, p. 1043. However, the Statement also corroborates the private PT provider's direct testimony that for young children with SMA, like petitioner, traditional measurements of strength are not possible, or at least not generally valid, and that the emphasis is on observation of function. Observation of function through time on task/goal and spirometry is what the private PT provider has documented on her POCs. I find she has identified his impairments as severe hypotonia and profound muscle weakness on all of the POCs in the 6 months prior to the instant PA. She has also provided her observation of function on each goal as the POCs progress. See Exhibits D-G. The progress has been summarized in Exhibit S. For Goal #1, petitioner's average time started at 60 seconds, then 68, then 53, and then 47. See Exhibit S. There was no dispute that petitioner had been ill between December and January when his times regressed from 53 to 47; however there was also no dispute that petitioner benefitted from the PT after illness, and which was the basis for the agency's decision to allow the 13 dates of service. Having no evidence or citation to authority that testing like the MMT is an absolute requirement to show baselines or measurements, I find that the observation of function here documents his progress toward meeting and maintaining his PT goals and that the provider has consistently used the objective unit of measurement of time over the course of the POCs. As to Goal #1 I find that the measurement of time for his ability to short sit at a bench, using the table as arm support, shows some progress has been made. I also note that his POC from May 2013 shows continued improvement with an average of 2.17 minutes.

As for Goal #2 - demonstrate expiration on the spirometer to 1400cc/sec – the provider clarified at hearing that this is not an exercise or therapeutic intervention; rather, it is a measurement for the work she is doing on his ribcage and spinal mobility, and shows lung function which relates to his endurance capabilities for the goals for sitting. Further, the goal shows some improvement in the last six months from 1000cc to 1200cc.

For Goal #3 - utilize upper extremities into the supporting surface for recovery in short sitting – the POCs show progress in that petitioner has moved on from being unable to steady himself at a table in short sitting, to being able to consistently steady his balance. The goal was then changed to utilize upper extremities for recovering from a loss of balance, rather than to remain steady.

For Goal #4 - When [redacted] is fatigued in short sit he will ask for a break rather than let himself fall over – it was determined at hearing that the purpose of this goal is related to petitioner's ability to communicate regarding his sense of balance and posture. This is a matter of safety during his gross motor activities. It has also shown progress over the last six months as when he began in July 2012 he would fall over with no regard for safety, but had improved by January 2013 to ask for help after fatigue was noted and a verbal cue given. I also note that another goal was discontinued in October 2012 for sustaining head control without a posterior support as that goal was met at that time.

Perhaps these improvements appear minimal, but with petitioner's particular degenerative disease the progress could be significant. And further, the clear language of the rule states that a PA will not be

approved when "the recipient has shown no progress toward meeting or maintaining established and measurable treatment goals over a 6-month period." Wis. Adm. Code, §DHS 107.16(3)(e)1.

Finally, the issue of whether the petitioner's HEP and PT at school (1x/wk) provide sufficient interventions. I find that the school PT is working on his mobility in his wheelchair. See Exhibit M. When petitioner is in his wheelchair he is supported by a seat belt, pads, a vest and a headrest. This does not serve to strengthen him in the way that the direct PT is doing. The HEP has a daily program to prevent contractures and a weekly program for strengthening. See Exhibit P. This does not account for the manual manipulations he requires to activate his muscles so that he can perform the exercises he needs to progress in or maintain strength, postural control or ribcage mobility. It also cannot facilitate the end ranges and mobility he experiences in the aquatic therapy.

In sum, I find that the preponderance of the evidence shows that the requested therapy is medically necessary and serves functional goals that can be carried over to the home, as improved strength and postural control carries over to all upright activities in the home and for breathing.

Finally, I note for petitioner that the PT provider will not receive a copy of this Decision. In order to have the PT services involved here approved, the petitioner must provide a copy of this Decision to New Berlin Therapies. The provider must then submit a new prior authorization request to receive the approved coverage.

CONCLUSIONS OF LAW

That the evidence offered on behalf of petitioner is sufficient to demonstrate he requires the requested 52 units of PT services (or twice per week for 6 months).

THEREFORE, it is ORDERED

That Petitioner's provider may re-submit a PA request for 39 units (52 requested – 13 already allowed) beginning February 8, 2013 of PT services and its invoice, along with a copy of this decision, to ForwardHealth for payment, and ForwardHealth is directed to make payment accordingly.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 31st day of July, 2013

_____

\sKelly Cochrane
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on July 31, 2013.

Division of Health Care Access And Accountability
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